## Medicare Part D Program Solicitation

**Fax To**: (262) 335-6221
Clint Gehring
Provider Relations Specialist
RESTAT
724 Elm Street
West Bend, WI 53095
(800) 926-5858

We wish to enroll in your program as a provider for Medicare Part D.

This is the following information about our pharmacy:

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Pharmacy Name: ______________________________________________

Address: _____________________________________________________

City: ____________________State: __________ Zip: _______

Phone: ( )____________________ Fax: ( ) ___________________

Email Address: _______________________________________________

NABP#: _____________________________

Medicare Provider #: ________________________________

Name: _________________________________ Date: ______________
(Print)

Title : __________________________________

Signature: ________________________________